The Manitoba Medical Review

Vol. 24 Winnipeg, March, 1944 No. 3

Foreword

Dr. Bruce Chown is responsible for the excellent idea of having laymen come before the Society in order to present their views on Health Insurance. The speakers were well chosen and set forth the views of their organizations clearly. When the matter came up for discussion in the Executive I asked the President to arrange for the Review to get the typescripts in time for publication in this issue. We felt that the opinions of the organizations concerned were of great importance and that they should be given the widest publicity among the profession so that all the doctors might learn about the view points and wishes of those who form so large a part of medical practice. The typescripts were received and printed without any changes on our part. Mr. King, president of one of the unions, attended and spoke but unfortunately did not give us his remarks in writing. He spoke along the same lines as the others but stressed the difficulties likely to be encountered by workers if the scheme were to be on a contributory basis. There were a few comments mostly laudatory to the speakers who certainly deserved them. Apart from these omissions the meeting is reported as it occurred. City members of the Society, who deal mostly with working men, and country readers whose patients are chiefly farmers will, I hope, find as much in the present issue as in the regular numbers which stress the methods rather than the economics of practice. J. C. H.

What Labor Expects from National Health Legislation

By Don Swailes, Secretary, Trades and Labor Council

The term "Labor" is quite broad. It covers the vast mass of people who live by the sale of their physical strength, their special skills, and their services of hand or brain.

It ranges from the manual laborer, rural or urban, to the professional, and managerial groups, and in every degree of this social scale it has become more or less articulate by virtue of organization in one form or another.

At this time I can speak only for that group, composed chiefly of manual workers, brought together by the incidence of their daily work into trade unions, usually referred to as "Organized Labor."

Sickness for the worker is a serious matter. In spite of the great natural wealth of this country, the general level of wage payment is so low, that the great majority of families are living under sub-decency standards, even though in a state of good health, and working every week of the year.

When sickness comes along, there are no reserves with which to meet the contingency, the living standard is still further lowered due to lack of earnings, and the doctor bill becomes a burden which is carried in many instances for years.

It is not surprising therefore, that organized labor, in its representations to provincial and dominion governments, has, for years, been demanding some form of health legislation which would ease the burden now being carried by those who become sick or injured.

In view of the general opinion of workers, expressed by their membership in the Manitoba Hospital Service Association, affecting over 100,000 persons in Manitoba, and in the medical schemes of the two railways, and the larger industrial establishments, the Winnipeg District Trades & Labor Council submitted the following to the Provincial Cabinet in November, 1943:

"We urge your government to take the necessary steps immediately, to establish a sound health insurance scheme, keeping in mind the desirabiity of such a scheme becoming national in scope, in line with evidence compiled in a separate volume of the Sirois Commission Report, (Book 2, pages 42 and 43).

"Such a scheme to provide free medical services, both curative and preventative, for workers and their families. Prescribed appliances and materials to be supplied, free treatment in public hospitals, and part payment of private hospital fees, maternity services comprising medical care before and after childbirth, free supervision and medical assistance during the first and most dangerous years of the child's life, with provision to assure against under-nourishment in the family life.

"The creation of a network of rural first aid posts, and travelling dispensaries for the purpose of free medical services to rural workers and their families."

At the last convention of the Trades and Labor Congress of Canada, held in Quebec City the first week of September, 1943, the following resolution was adopted. It represented the opinion of some 300,000 workers with specific resolutions from Moncton, N.B., Calgary, Alta., Fort William, Ont., Toronto, Ont., and Winnipeg, Man.:

"Whereas it is acknowledged that the need for conservation of mental and physical health and fitness is greater today than at any time in the nation's history. . . . . Be it resolved, that this 59th annual convention of the Trades and Labor Congress of Canada urge the Dominion government to seek the co-operation of the Provincial Governments and Medical Associations, and such other agencies as are interested in better public health, in the enactment of a national health insurance scheme on a contributory basis at the next session of Parliament, in order to eliminate all unnecessary loss of health, life and money, and further, that any such National Health Insurance scheme should be formulated and administered in such a way as to give the best protection against ill health and accident to the masses of the people at a minimum of cost, rather than be designed merely to make of the Government a collection agency for members of the medical profession."

Those two representations are submitted at this time to indicate that there is a widespread demand for a national health bill, and that the time is long overdue for the enactment of such legislation.

They cover a great deal of ground. They include preventative as well as curative action, and they include mental, as well as physical conditions. They cover the field of industrial life, as well as that of civil life.

By the very nature of their lives, workers stress the necessity of preventative action particuarly in the industrial field.

Only too often, under the stress of competition, the physical well-being of workers is overlooked in industrial establishments. In many cases, even organized workers are powerless by themselves to improve those conditions, and as a result the aid of the state, or of some power higher than that of the employer is sought.

With all that has been done in the past, there still remains a great deal to be done in the way of guarding machines, of improving ventilation, of removing obnoxious fumes, and dangerous dusts, of better lighting, of guarding against excessive fatigue, and deadly monotony, in better sanitary and recreational facilities.

Even if all these preventative measures of a physical nature are undertaken successfully in industrial establishments, there still remain psychological problems to be tackled.

What is the effect on the health of a man or a woman, who is day by day subject to the tyranny of a thoughtless overbearing bully of a foreman or employer, without any means of self-defence except that of leaving the job and facing the possibility of a long spell of unemployment?

What is the effect on the social mentality of men, when they are obliged to spend the greater part of their daytime hours working merely as cogs in a machine in mass production plants? How can they be expected to retain a sense of responsibility to the community, when they are not allowed to exercise any responsibility in a workshop?

Those are some of the things that workers expect to be taken care of as far as industrial life is concerned, by national health legislation.

It is only natural that, as a result of industrial experience, workers should look to preventative action, rather than curative in the field of civic life, in a national health programme.

Only governmental action, Dominion, Provincial or Municipal, can improve the cleanliness of our cities. More flushing of streets to wash away disease laden dust, more adequate disposal of sewage, more frequent collection of garbage, better housing, better lighting, and a wider knowledge of personal, family, and social hygiene. Only governmental action can assure general, periodical examination, inoculation, and similar preventative activity. With all this, when sickness or injury does come along, what does the worker expect?

He expects the same standard of medical, surgical, and hospital care that is given to the wealthiest members of the community, by virtue of his contribution to society in the way of labor.

Speaking on a proposed measure for health legislation, at the Forty-second Annual Conference of the British Labor Party, held in London, June, 1943, Dr. Somerville Hastings included the following.

"This service unites two principles; firstly that nothing but the best is good enough in health matters, and secondly that the best can only be obtained by doctors and nurses who give their undivided attention to the pubic health service. Therefore I think it follows that there can be no place in such a service for the panel and for the voluntary hospital scheme, by which doctors give part of their time to their public duties and part to their private practice. The doctors and everybody else concerned must be full-time officers in such a service.

"A century ago there was suposed to be a cure for every illness, and that you had only to bring the doctor and the patient together, and that was the most you could do. Now we know that health is a public matter, of interest to all; that not one doctor but a team is required for efficient treatment; that medical science and the medical services, like the army have been mechanised, so that what you want is not only a doctor with a black bag, but you want for efficient treatment, hospitals and X-rays, and pathological services, and so on. We also know that there is something better than the cure of disease, and that is the prevention of disease."

This, I think, expresses admirably the expectations of workers from a National Health Service.

This opens up the field of discussion on contributory, or non-contributory legislation. Some workers claim that this service should be free. They claim that they get little from society in return for their labors. That they have had little from society in the way of education. That in a world of fine subdivision of work and function, the work of a street sweeper may be of greater value to the community by prevention of disease, than the work of the medical man who tries to effect a cure. That by their contribution to society, however humble, they are entitled to whatever society can give in return, in maintenance of health and curing of sickness.

Others take the point of view that it should be contributory, that they are not out for "something for nothing" that by making a monetary contribution they can accept health service without lessening their feeling of independence, without feeling they are accepting charity.

Whichever line is taken, the fact is that health service is a community service, the cost of which would be borne either from general taxation, or from a special levy, which in the end amounts to almost the same thing.

The position of the medical profession, under such a scheme, is the particular worry of the medical profession, not that of the worker who has plenty of worries of his own. However, the worker does have thoughts on this aspect of health legislation.

He will resent and oppose any health scheme which will mean merely a prepayment of doctors' bills, which will place the government in the position of a collection agency for the medical profession.

The worker regards the member of the medical profession as a preferred element in society. His social standing is guarded and regulated by law. During his period of study, he receives far more from society than he gives, having the accumulated knowledge of the race presented to him almost as a gift. He can only go to work as a doctor after passing an examination, the severity of which limits the numbers who can enter the profession. The supply of doctors has never equalled the demand. Consequently the worker takes the point of view that the doctor should give to society, some return for the advantages he gets.

With health as a national service, doctors to be paid by the state. Paid well, and not overloaded with work, so that adequate time can be given to every case for examination and diagnosis.

Such a health service to be universal, every man woman and child in the country participating. We are opposed to any form of health insurance which would include only a portion of the population. There should be no such thing as an income ceiling under which persons would be eligible for health service and over which they would pay for their own. For instance, if only those with incomes of $2000.00 a year or less participated in the health insurance scheme, and those with over $2000.00 a year paid for their

own medical services, there would be the danger of establishing a double standard of health service. One for those under the insurance scheme and one for those who were not.

To summarize: Without doubt workers want national health service.

The first consideration, preventative, then curative.

It must be universal.

Contributory or non-contributory is controversial.

Position of doctors under the service is one for the medical profession to determine with government.

A Farmer's Views on Health and Medical Services

By B. E. Lewis, Secretary Manitoba Federation of Agriculture

Mr. Chairman, Ladies and Gentlemen:

As I am speaking in a representative capacity, I have drawn upon the following sources for the most of the information upon which my remarks are based.

1. "Health on the March"—Principles of a Plan of National Health Insurance submitted by the Canadian Federation of Agriculture.

2. The reports of Manitoba Farm Radio Forum groups of this season and National Farm Radio Forum literature.

3. Canada's Health—by Mr. Geo. Hoadley, published by the National Committee for Mental Hygiene.

4. The Department of Health and Public Welfare—Manitoba.

5. The Department of Municipal affairs—Manitoba. This source deliberately to secure authentic information in support of eight years' experience a few years ago, as a Councillor and Reeve.

6. Economic Survey Report—Manitoba, and the Manitoba Submission to the Rowell-Sirois Commission. Also other sources of an incidental and miscellaneous character.

I understand that a distinction is drawn between the fields of **Public Health** and **Medical Services** but I am not going to attempt to define those fields or to discuss them separately as such. I wish only to convey to you farmers' opinions and ideas regarding the problem of keeping people well and curing them when they become ill. To accomplish this, a task which concerns us all, and an end which we all desire to attain, it is necessary that we as farm people, and you as Doctors, enjoy mutual confidence.

Rural Conditions As I See Them

As part of the Farm Radio Forum broadcast of December 6th the following question was asked:

"To what extent is preventive medicine along these lines practised in your community? Replies may be listed under: (a) regular examination, (b) early diagnosis, (c) immunization, (d) pre-natal and post-natal examinations."

The summarized replies to this question were reported by myself as follows: "The replies to this question are anything but cheerful. In fact they indicate a very serious condition in rural Manitoba, from the standpoint of organized preventive medicine. Under heading (a) only 4 groups reported regular examinations in their communities; 12 groups reported no regular examinations and 7 groups reported examinations of an irregular character. (b) early diagnosis: only 2 groups reported this service as good; 3 groups reported the services being carried on in the schools, and 15 groups reported very poor or no such service. (c) Immunization: Only one group reported a good service of immunization. One group—some service but not organized. Two groups reported none, four groups reported some service and ten groups reported the service being carried on in the schools. (d) Pre-natal and post-natal examinations: 2 groups each reported as follows—well organized; service available but not organized; and fair. Six groups reported the condition as poor and 5 groups referred to lack of finance as an obstacle to adequate care."

As a cross section of opinion over the Province, I present the following detailed Forum group reports on the questions just summarized.

1. **Basswood**—"We are under the Municipal Doctor system and have the privilege of taking the preventive measures."

2. **Morris**—"(a) Regular examination, very irregular; (b) early diagnosis, no special place; (c) immunization, almost not at all or at long intervals; (d) pre-natal and post-natal examinations, individuals are becoming more conscious of such services where money permits."

3. **Souris** — "Examinations are not regular. No early diagnosis except in cases where there are T.B. suspects in a family. Immunization entirely at discretion of the parents and local doctor. Cost is borne by Municipality. Pre-natal and post-natal care in this district is entirely up to the individual and local doctor. There used to be a provincial nurse in the early 1930's but as near as can be learned she was starved out."

4. **Swan River**—"Regular examination—this phase of health protection is badly neglected. Early diagnoses are few due to the lack of regular examinations. Most cases have become well advanced before a doctor is called. Lack of funds bring about too many useless home remedies."

5. **Glenella**—"We, ourselves, have suffered the loss of two children for want of medical care when urgently needed. In the first instance there was no money to pay the doctor as the grasshoppers had taken the crop. The other child took infantile paralysis, was taken 35 miles to the doctor and died 39 hours later."

6. **Kergwenan**—"Usually people wait till they are half dead before visiting doctor, we always hope the pain dies down."

7. **Alexander**—"We are under a Municipal Doctor system. In the meantime doctors are so far between that our doctor is covering more than his prescribed area. But even at that I think most of the ratepayers have examinations as often as they are asked for. Immunization is given to children. Pre-natal and post-natal care is given to all who want it."

Let us examine for a moment the relative positions of our Rural and Urban communities from the standpoint of available medical services. In 1936 the population of Manitoba was 56.28 percent rural and 43.72 per cent urban. I do not believe that any marked change in this position has taken place since 1936.

From information obtained from our Provincial Department of Health I submit the following: There are approximately 450 doctors in general practice in Manitoba, of which 112 are serving the rural areas, exclusive of cities. Serving our cities we find the

following: Portage la Prairie, 3 doctors to 7200 people, an average of 1 doctor to 2400 of population. Brandon, 9 doctors to 15,000 people, an average of 1 doctor to 1666 people. Greater Winnipeg, 311 doctors to approximately 300,000 people, slightly less than 1,000 people per doctor. In this connection, let us remember, too, that our cities have modern hospitals and trained nurses, public health services, modern sanitation, pasteurization and a host of other good things. Serving rural Manitoba, we find 112 doctors trying to serve a population of approximately 400,000, or an approximate average of one doctor to 3,571 people. From this standpoint, the best served rural area is that centering upon Minnedosa, a municipal doctor area, with one doctor to 1800 people. The inter-lake area has one doctor per 3,500 people and an area comprising the south-eastern corner of the Province, one doctor per 5,000 of population.

These facts disclose the serious circumstances in which our farm people find themselves, circumstances which become more serious still on account of distance of travel, roads, weather and other obstacles. The Forum group at Lenswood reported—"As there are only three doctors in over 300 miles we seldom have been able to get a doctor if needed."

Rural conditions are further reflected by a brief examination of the position of our Municipalities. Exclusive of the cities, the total expenses of Manitoba municipalities in 1939 amounted to $8,177,619.00. Of this amount $971,089.00, between 9 and 10 per cent, was spent for social services. During the same year, from this item, $120,097.00 was spent directly on health and $201,436.00 for hospitalization. At the end of 1939, outstanding hospital accounts receivable amounted to $946,668.00. For the year 1942 the situation was as follows. Total expense $8,609,422.00; Social services, $793,491.00; Health, $174,305.00; Hospitalization, $128,570.00. Outstanding hospital accounts receivable, $1,266,302.00. Even these large amounts of outstanding accounts are not complete as some municipalities do not charge them up. It is not difficult to see why our hospitals sometimes experience financial difficulties.

From a national standpoint also, inequitable distribution of medical service is apparent. Quoting "Canada's Health", 1940. Ontario had one doctor per 1034 of population; Saskatchewan, one to 1578. For dentists, Ontario, one to 1879; Saskatchewan, one to 4134. Graduate nurses, one to 351 persons in British Columbia; one to 859 in Saskatchewan.

Why These Conditions?

I am not surprised that we have such an uneven and unfair distribution of doctors and other professional personnel, nor am I surprised that our rural people have been the ones who have borne the brunt of these conditions, and I wish to make it clear that I do not blame the medical profession. Doctors have to live too. Also, they should have available to them modern facilities, which in our rural areas, are conspicuous by their absence.

Agriculture is Canada's basic industry and it has been exploited to the limit by every possible contrivance that the world of modern business has been able to apply. The facts and conditions which I have cited to you, reflect only one phase of a general condition.

How can we ever hope to correct the mistakes of the past and build a true democracy until we approach problems of a national character in a spirit of social consciousness? As farm people, I think we have started along this path. Our co-operative movement, operating soundly and successfully, has brought new hope to thousands of farm families. The old attitude of uncompromising self-reliance has given way to the acceptance of a sensible policy of mutual aid, wherein the strength of individual character, the talents and ideals of men and women, and the enthusiasm and wisdom of young and old are blended for a common purpose. It appears natural, therefore, that, as farmers, we should approach the question of Canada's health, from a national standpoint. Canada's health is a national problem in which every Canadian should be concerned and which requires the earnest and active consideration of all if a satisfactory solution is to be found.

Principles Enunciated by the Canadian Federation of Agriculture

The Canadian Federation of Agriculture, representing approximately 350,000 farm families, at the request of the Federal Department of Pensions and National Health, submitted to the Advisory Committee on Health Insurance, eight principles which the Federation considered should be incorporated in a National Health Insurance Plan for Canada.

Principle Number 1

The Dominion Government should enact legislation for a National health insurance plan for Canada.

(a) The large majority of the people are unable to pay for adequate medical care with its rapidly increasing scope and costs; while at the same time, those who give the services are not receiving a just remuneration. This state of affairs is having a serious effect on the welfare of our Dominion.

(b) Health is a national problem which is becoming more and more evident under the stress of war conditions. The responsibility of the Federal Government in calling on man and woman power from all classes entails Federal responsibility for the people's health.

(c) A national health plan would encourage a strong national sentiment. Confederation was intended to foster a national economy. There is now urgent need to revive this interest.

(d) Regional planning must now be done with vision; and it is imperative that the Federal Government give leadership in this work. The whole country should be mapped out to show the proper distribution of hospitals, equipment and personnel needed to serve the population as a whole. Only in this way could adequate distribution of facilities for a national Plan be accomplished.

Principle Number 2

The Plan should be administered under the direction of an independent commission at Ottawa.

This commission should be composed of representatives of those giving and those receiving the services, the majority of representation to be lay people. Thus, finance, industry, labour, agriculture, welfare and others will assume their proper function.

Principle Number 3

The legislation should provide that the central commission shall function in each province through an independent commission appointed by provincial legislation, representation to prevail similar to that of the central commission.

This set-up would obviate any conflict of authority between the Dominion and the Provinces.

Principle Number 4

The cost of the plan shall be defrayed from the Federal Consolidated Revenue Fund.

(a) This is the most direct and economical system of providing the money. It would entail no extra work or cost of administration—the one yearly collection would suffice. This would be the people's contribution, collected through the customary channels.

(b) The Report of the Royal Commission on Dominion-Provincial Relations accentuates the need for a central authority to obviate dangers of fluctuation of provincial income during depression periods.

(c) This system of financing will mean equity so far as the individual citizen is concerned, in whatever province he happens to live; which could not be the case if there were nine methods of raising funds, with varying burdens of taxation to the individual citizen.

Principle Number 5

The Plan should include all citizens.

(a) This is imperative because to adopt any other policy is to deny Democracy and to destroy national unity. The Gallup Poll of the Canadian Institute of Public Opinion showed that 75% of the people—men and women, rich and poor—were in favour of a National Plan.

(b) Complete coverage is necessary to achieve financial soundness and to spread the cost equitably. Any "ceiling" imposed on who shall be recipients of the benefits of the Plan would cause endless confusion when there was a fluctuation of individual income.

(c) Canada has an increase in both the diseases of later life and the proportion of older people. Therefore, if we are to plan for improvement in this situation a generation hence, we must encourage service to ALL the people; and there must be no penalizing of citizens with growing families. Also, it is obvious that unless all the population is in the Plan, preventive health measures cannot operate effectively to serve and protect the whole community."

The trend of Canada's ageing of population is shown by the following: The number of 65 years and over per 1,000 of population.

Year	
1871	36.4
1911	46.6
1931	55.5
1941	65.1

Principle Number 6

The Plan shall include all services necessary for the promotion of positive health, and the prevention and curing of disease.

Principle Number 7

The promotion of positive health and the prevention of disease shall be the primary purpose of the plan.

(a) This two-fold purpose must be integrated with the practice of medicine, and not considered as at present—merely a subsidiary under Public Health. Although the need for curative measures is fully recognized, we have not begun to realize the possibilities for improvement when all the community is organized in a Health programme. Our planning must be with this end in view.

(b) This entails a better method of statistical recording than exists at present; the object being that the health progress of any part of the country can be detected at a glance. This would be complementary to the present movement for better vital statistics—both mortality and morbidity.

(c) The family must be taken as one complete unit, so far as their healthy environment, proper nutrition and health guidance is concerned—and not, as at present, where the father may consult one doctor, the mother another, and the health of the children and the welfare of the family as a whole be left to chance.

(d) We visualize the general practitioner as the very foundation of the success of the Plan. On his shoulders rests the promotion of positive health and the drastic curtailment of the diseases and abuses under which the people at present labour. The general practitioner must be strategically placed and well remunerated; and all services necessary for the success of his important work must be easily available. It is because the general practitioner in the past has been frustrated by the economic set-up that the people have suffered needlessly, and that there has not been the advance in national health, paralleling that of science. The growing population of our mental institutions and the sick in our hospitals (the majority of whom should not be there) is an indictment of our present situation. Therefore, the Plan must be so organized that the general practitioners can "go all out" on a co-ordinated, militant campaign for health. This will mean an entire change in the attitude of our medical schools, the education of all health personnel, and the proper integration of research into the Plan. We believe that this will be to the advantage of both those giving and those receiving the services.

Principle Number 8

We believe that community effort must have a place in the plan. Since Municipal Health Services in many Western municipalities have proven an ideal system for the practice of preventive medicine—in raising the standard of community health, radically lowering sickness and death rates, and decreasing the need for hospitalization — every opportunity should be given within the National Plan for the preservation and enlargement of this method of providing services locally. Maximum efficiency and practicability should be sought, through local democratic participation of the people served. The dynamic of the rural community must be utilized in a programme for better health.

A two-year survey of the work of the municipal doctors in Manitoba was made from May, 1938, to April, 1940, through the generosity of the International Health Division of the Rockefeller Foundation and with the assistance provided by organized medicine in Manitoba. The results were outstanding. Briefly, they were as follows: The maternal mortality rate was nil, as compared with the Provincial rate of 4.3 per 1,000 live births. The infant death rate was almost 14 points lower than the Provincial rate—40.2 as against 54 per 1,000 live births. The "disability" or sickness rate was only 2/5 of the accepted rate for Canada. The hospitalization rate was only 1/3 of the Provincial rate. Doctors reported three times more people were seeing them in their offices than they had to attend in their beds at home —in other words, they were nipping serious illness in the bud. The cost of this work was only 44% of the cost of work done by doctors in a municipality where the system of fees prevailed.

We believe in these broad principles for National Health Planning; and we realize that details cannot be worked out until all committees meet and pool their views. Therefore, we anticipate this opportunity being given to all representatives of those who would be giving and receiving services under the Plan.

Where Will the Money Come From?

Someone will probably ask the practical question, where will the money come from? The technical answer is, from the consolidated revenue fund, but, this is not the reply that I wish to give at the moment. I submit that we have in this country, the natural resources, the manpower and the ingenuity to provide adequately, yes even generously, all of the necessaries that are required to provide our people with a balanced standard of living. I do not mean to imply by this statement that we should even consider a policy of narrow economic nationalism, but by being sensible, and by being true to the principles of democracy and

human decency, by putting first things first, we can establish a solid foundation of good health, upon which we can, as a nation, erect a superstructure in keeping with our day and age.

Agriculture is willing, yes anxious, to contribute its share. Why not? As farm people we cannot lose; as we have in the past, and still are carrying the burden of inadequate and discriminatory health protection, the dividends of which are measured in terms of needless death, human suffering, economic loss and the general lowering of our cultural and social standards. To enable farm people to carry their just portion of such social obligations, it will be necessary to prevent the recurrence of certain unsound and vicious practices of exploitation to which they have in the past been subjected. Certain business and financial interests will have to be removed from their positions of eminence and become relegated to their rightful places in society, whereby they shall become servants rather than be lords and masters of a body of men and women worthy of the title of nation builders.

May I give you a few examples of what I mean? A farmer in 1910 borrowed $1,100.00 at 8 per cent and has to date paid $2,800.00 and still owes over $600.00. Another, who paid on a mortgage of $5,000.00, $13,500.00 in interest alone. One more—a loan of $7,000.00, paid in interest $6,500.00, in principal $1,500.00, erected buildings to the extent of $9,000.00. This farmer was told in my hearing that he had no equity in the farm and was dispossessed, while his son was piloting a bomber, to save the world for Democracy. We are told, and we hope that a better world is in the making. As intelligent people we know that we must build that better world. We can only do it by working together.

Farm people generally, I believe, look upon their doctor as a friend. I know that is the attitude of my own community towards our doctor, who is the friend of all as well as being the municipal physician.

It may be that the principles enunciated by the Canadian Federation of Agriculture may require changes or modifications, to be acceptable to you. If that be so, it does not worry me. The honored record of the medical profession, throughout the years, leads me to believe that its members will co-operate in establishing such a plan of National Health Insurance, as will be reasonably equitable and which will recognize and glorify the sovereignty of human life.

Dr. Jackson's Comment

Mr. Chairman, Ladies and Gentlemen:

The Executive of the Winnipeg Medical Society are to be congratulated on arranging this meeting tonight, making it possible for us to ascertain the viewpoints of Agriculture and Labor in respect to Health Insurance.

The presentation of both Mr. Lewis and Mr. Swailes show that both agriculture and labor have given a lot of thought and study to the problem of more adequate medical care. Their talks were clear and their opinions in respect to Health Insurance quite definite. I am sure all of us were struck by the fact that they do not conflict on any major point with the views of medicine.

After fifteen years of watching Governments operate I am convinced that if and when Health Insurance becomes a problem for the Provincial Legislature to discuss, it would be highly desirable that all groups in this community, both those who will provide the service and those who will receive it, should be of one voice on the general principles that would seem necessary to bring into being a satisfactory scheme. If they are, any Government will listen and provide what the public want.

In my opinion it is up to medicine to take the lead in crystallizing public opinion, and for this purpose should continue meetings such as this. They should go further and take the initiative in getting representatives of all groups to sit around a table and prepare a plan which, in the group's opinion, is workable and will give the results we all desire. Most persons and groups are reasonable and there should be no great difficulty in ironing out any differences we may have, and be in a position to intelligently assist the Government in providing a worth-while service.

F. W. Jackson, Deputy Minister,
Dept. of Health and Public Welfare.

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In all things relating to disease, credulity remains a permanent fact, uninfluenced by civilization or education.—Osler.

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March Medical Happenings

Luncheons

2nd, Thursday, 12:30, Winnipeg General Hospital.
7th, Tuesday, 12:30, Misericordia Hospital.
9th, Thursday, 12:30, St. Boniface Hospital.
14th, Tuesday, 12:30, Grace Hospital.
16th, Thursday, 12:30, Winnipeg General Hospital.
21st, Tuesday, 12:30, St. Joseph's Hospital.
23rd, Thursday, 12:30, St. Boniface Hospital.
31st, Friday, 12:30, Victoria Hospital.

Winnipeg Medical Society

17th, Friday, Regular Meeting, Medical College, 8:15.
24th, Friday, Medical History Section, Medical Arts Club Rooms, 7:30.

Tumor Clinic

Winnipeg General Hospital, Every Wednesday, 9 a.m.
St. Boniface Hospital, Every Tuesday, 10 a.m.

Ward Rounds

Every Thursday, 11 a.m., Children's Hospital.

American Physicians' Art Association

will have its seventh annual exhibit at the A.M.A. convention, Stevens Hotel, Chicago, June 12-16, 1944.

Everyone was impressed by the beauty of the Art Exhibition at the Atlantic City Session last year, but the 1944 Gallery in the main ballroom balcony will be even more beautiful and impressive.

Through the courtesy of Mead Johnson & Co., Evansville, Ind., there will be no fees for hanging and no express charges either way. The type of art to be exhibited includes personal work of the following types of medium: oil portraits, oil still life, landscapes, sculpture, water color, pastels, etchings, photography, wood carving, leather tooling, ceramics and tapestries (needle work). All pieces should be sent preferably by railway express collect, automatically covered with $50 insurance.

Exhibitors should send now for entry blanks to Dr. Francis H. Redewill, Secretary, A.P.A.A., Flood Building, San Francisco; one entry blank should be used for each medium in which it is desired to exhibit.

There will be about 100 trophies, including medals and plaques.

Case Report

Pneumococcal Meningitis (Type III) Secondary to Otitis Media and Mastoiditis, Treated with Penicillin---Recovery

E. H. Alexander, M.D.

This man, A.T. age 37 years, had an acute Otitis Media early in December following an attack of influenza. During his initial illness he was given 300 grains of Sulphathiazole and his ear became quiet, temperature and pulse normal, and apparently the disease process in the mastoid cells was subsiding satisfactorily.

On December 31, 1943, the patient developed a severe occipital headache, vomited twice, perspired freely, and by early evening when I saw him, he was semi-comatose and had a definite paresis of the face, with ptosis of the left upper lid. The patient was admitted to the Winnipeg General Hospital. A lumbar puncture was done with an initial spinal fluid pressure at 450 mms. of water; 6 cc of milky fluid were removed, and on pathological examination this was shown to be type III pneumococcus. The pressure was brought down to 220 mms. of water, and an emergency mastoidectomy was done, immediately after admission. The sinus and dura were completely exposed, the mastoid tip was removed and the facial sheath laid bare.

On return from the operating room the temperature was 100.2, pulse 70 and respirations 20, leukocyte count 12,950. The patient was given 20 cc of soluble Sulphadiazine, and was given 15 grains of Sulphadiazine OH4 with 30 grains Soda Bicarbonate per Ora for a period of two days. During this time the patient remained comatose and was terribly confused and irrational.

On December 24th the temperature was 104.2, pulse 130, respirations 28. The patient was still very restless and comatose, voiding involuntary, had marked abdominal distention and was apparently making no response whatsoever to the sulfa drug. At this time his spinal fluid pressure was: initial pressure 600 mms. plus, of water, final pressure 290. We removed 45 ccs. of milky spinal fluid with considerable flocculent material. The swab from the mastoid, the spinal fluid, and blood cultures were all positive pneumococcus type III.

The patient was seen in consultation with Dr. Lennox Bell and Penicillin was instituted. 10,000 oxford units of Penicillin were given in 10 ccs. of saline intrathecally, and a continuous intravenous drip of 5% glucose and saline started, running about 40-50 drops per minute, and 10,000 oxford units of Penicillin were given into the tube every two hours.

In the first twenty-four hours of the Penicillin treatment, the patient was given 20,000 units intrathecally, and 120,000 units intravenously. In all the patient was given 50,000 units of Penicillin intrathecally over the period December 24th to 28th, 260,000 units intravenously over the period December 24th to 31st, and 530,000 units intramuscularly over the period of December 26th to January 4th, a total of 840,000 units of Penicillin over a period of twelve days.

The spinal fluid varied from the initial pressure of as high as 660 mms. of water on December 24th with 2870 cells per cu. mm., to January 3rd when initial pressure was 180 mms. of water and there were 95 cells per cu. mm. The temperature came down gradually step by step from December 25th until December 29th when we endeavoured to reduce the time from two to three hour intervals of our Penicillin injections, and the temperature gradually went up to 101.2. When the two hour interval was resumed the temperature came down to normal and the spinal fluid pressure became normal and equalized. On December 29th the patient's haemoglobin was down to 50% and he was given a transfusion of 200 ccs. of matched blood. He was given 250 ccs. of matched blood December 31st, January 1st, 3rd and 4th.

Thirty-six hours after Penicillin was started the patient's general condition was markedly improved and with each day there was definite improvement in his general condition. The mastoid wound filled in quite satisfactorily, the patient became quite rational, was eating and sleeping well, and the facial paresis cleared up. He was gradually allowed to exercise his limbs and after a period of ten days in the hospital getting out of bed and walking about the room, he was discharged in quite good physical condition, with the exception of a slight diplopia and paresis of the right external rectus muscle which has now, one month later, practically cleared up, and the patient is carrying on a normal every day existence without sedatives or any treatment whatsoever.

This case, I think, is interesting for three main reasons: First, Otitis Media with involvement of the mastoid, treated with Sulfathiazole or any sulfa drug, must be carefully watched, as while the ordinary symptoms apparently subside, there is still a "sleeping" process going on in the mastoid cells, and in spite of indefinite x-ray findings, a normal leukocyte count, temperature, etc., many of these mastoids should and must be opened.

Secondly, I feel that transfusing of whole blood, in not too big transfusions, 200-250 ccs, is of definite benefit in lifting these patients over the rough spots of exhaustion and dehydration.

Thirdly, but by no means last, I feel certain that with the Penicillin given at this time, that is in the comparatively early stages of a pneumococcal meningitis where the sulfa drugs are not being effective, it is a most spectacular and life-saving implement in the treatment of these cases.

Dr. Phillip Greey, of the Banting Institute, Toronto, informs me that this is the first case, in an adult, of recovery from pneumococcal meningitis type III, using Penicillin. I am indeed most grateful to Dr. Greey for his generous and prompt response to my request for Penicillin, and to Doctors Lennox Bell and E. J. Washington for their most valuable assistance in the handling of this case.

Winnipeg Medical Society—Notice Board

C. M. STRONG—*President*
P. H. McNULTY—*Vice-Pres.*

Next Meeting March 17th

W. F. TISDALE—*Secretary*
H. M. EDMISON—*Treasurer*

What happened last month you will find throughout this issue. This month the programme will be in the hands of the Radiologists and I understand Dr. J. R. Davidson has been invited to tell us about his cancer treatment.

Alphabetically the times are definitely out of joint for while we still await the "P's" we are surrounded by "Q's." Recently a drug store advertised that chocolates would go on sale at a certain time but long before the hour prospective customers were lined up for nearly two blocks. Every day at the Liquor Stores there are similar lines and now, or shortly, we may see them filling the hospital driveways.

The Hospital situation is rapidly becoming serious. One hears alarming stories. A patient with acute appendicitis must wait at home for 48 hours. Another with heart disease and pneumonia is deprived of the chance that hospital care would give her. Still another, bleeding dangerously, is driven from hospital to hospital seeking one with an empty bed. Others who have paid for hospital benefits can find no hospital where they can receive them. Surgeons are going on holiday; they cannot operate on kitchen tables and the hospitals have no beds. Here is a matter of prime importance which hospital authorities and the profession must speedily settle, otherwise some catastrophe will rouse the press and the public to demand a remedy. Perhaps it might make a proper study for the Hospital Section of this Society.

Liquor queues, also, are not beyond professional concern. I have been told (with what truth I know not, for I have no personal knowledge of such matters) that the liquor dispensed on prescription is of the variety known as "rot-gut" and is very lousy. I have this information from careful doctors who sample the medicines they prescribe in order to make sure that their patients get the right thing. Personally, I cannot distinguish between a spirituous masterpiece by John (or is it Hiram?) Walker and the crude attempts of a junior assistant to a third-rate bootlegger. Yet there are times when, on the best scriptural authority, one advises a little wine for the stomach's sake or, more often, a little brandy or whiskey for the heart's sake. It is unfortunate if, in order to assure the patient's getting the best a prescription is issued which results in his getting the worst. The adulteration of liquor was at one time regarded as an offence so unspeakable that jurists found it hard to devise a punishment that would even approximately fit the crime. But that was B.G.L.C.C.

For many centuries alcoholic drinks have been used as remedies. It was believed that they contained the literal spirit of vegetation — the essence of life — and, therefore the enemy of disease. All primitive peoples found some way of coaxing this spirit into solution, the process reaching its culmination when some nameless but inspired Scot wedded the peaty waters of his native burn with barley (which he had probably stolen from some unsuspecting Englishman). Thus came into being the supreme inspirer of songs and singing — and, more to the point — a most valuable remedy for the elderly and arterio sclerotic.

More ancient but less important from the therapeutic standpoint is beer. It was a very common remedy among the Egyptians who, incidentally, claimed it was invented by Isis. It is mentioned many times in the Ebers Papyrus. It was prescribed as plain, sweet, bitter, cold, warm, flat, and as froth-of-beer, lees-of-beer, swill-of-beer, yeast-of-beer and so on. It was also used as a vehicle for such potent remedies as clay-from-a-statue, womb-of-a-cat, tail-of-a-mouse, leather-from-the-sandal-maker, bat's blood, gazelle's ears, fly specks, excrement of a scribe and so on. The latter two items were regarded as very choice, the first because of their minuteness, the second because of scarceness, scribes being few and costive.

In Anglo-Saxon times beer was still a principal vehicle and was the basis of a sure-cure for lunacy 500 years ago. Madness, in those days, was held to be due to possession by devils — nasty little beasts that could be driven out only by making their domicile untenable. To this end our medieval predecessors proceeded as follows: They gathered some 20 or so plants, mostly ill flavored, and these they infused in beer. Then were added oil of garlic, juice of herrings and holy water. Over this were said seven masses and the "leprous distillment" was then drunk out of the church bell. One such draught was calculated to expel from the patient everything not tied down and the devil had no choice but to flee and leave his victim sane.

It is only 70 years since beer ceased to be a regular ration of nurses in certain English hospitals, and among the instructions of Radcliffe Infirmary we find this interesting note: "any strong beer that is not fit for drinking will be an agreeable present for the surgeons." That's telling them off! To be sure, they had just lately parted company with the barbers but still one wonders at the surgeons relishing such presents. The answer we find elsewhere — this worthless beer was used for poultices — Beer Poultices! — just think of such things here. Can't you imagine the following conversation: Doctor to Nurse: "Where are all those poultices I ordered you to apply?" Nurse to Doctor: "I'm sorry, sir, but the patients drank them all up." The hospital situation is bad enough without beer poultices to make it worse.

"Fair Padua Nursery of Arts," famous as the locale of the "Taming of the Shrew," and Bologna, basely famous as the birthplace of a sausage (no coupons required) are on the itinerary of the Medical History Section for March 24th. Our guide will be Professor Thompson. I do not expect that he will have much to say about either shrews or sausages, not, at least, until he has told us a lot about Vesalius, the greatest and indeed the first of Renaissance anatomists; and Sanctorius, who was the first metabolist; and Fabricius, who described the valves of the veins; and Harvey, who was by that discovery inspired to solve the mystery of circulation; and Malpighi, who actually saw, what Harvey had only guessed, the actual passage of blood from the arteries to the veins; and Fallopius, who gave their names to hard palate and soft palate, vagina and placenta; and gave his own name to the aqueducts and oviducts.

Vesalius left Padua to become court physician to the Emperor Charles V. For twenty years "he bent his knee to pilfering bishops and luetic Dons." He languished in wealth and luxury but there was no dissection in Spain — his Gilead was balmless. In Padua Fallopius was finding faults in the works of his great master. The master was stung to retort and action. But his thraldom ended in a strange way. A nobleman having died with his ailment

undiagnosed Vesalius decided to perform an autopsy. He took his knife, made his incision, opened the chest and saw — a beating heart. His own almost stopped. About him his enemies and the Inquisitors saw their opportunity and hastened to heat their irons and prepare their tortures. Only the influence of the King spared his life. He was ordered to make a pilgrimage to Jerusalem but the vessel in which he sailed was wrecked upon the Island of Zante. Ailing, injured, nearly drowned, he dragged himself to a nearby and isolated hut. There a passing stranger later found the honours, glories, triumphs, spoils of the great Vesalius shrunk to the narrow measure of a festering, putrid corpse.

J. C. H.

Hospital Luncheon Program Reports

Grace Hospital

The regular monthly Clinical Luncheon at Grace Hospital was held on Tuesday, February 15th, 1944 (held on the 3rd Tuesday of each month).

Dr. J. S. McInnes presented a very interesting case of Vesico-Colic Fistula—The patient also had (or recently had) several other conditions hardly related to the condition discussed, e.g., a Cholelithiasis with impacted stone in the common duct—a pregnancy—uterine fibroids—a peri-rectal abscess. The cause of the Vesico-Colic Fistula was thought to be a diverticulitis of the colon. Dr. C. Burton Stewart reported on the findings in the urinary tract and showed several x-rays of the investigation findings — several discussed the case. The patient is now doing well—following a colostomy—and we hope to have a further report on this case in due course. F.A.B.

St. Boniface Hospital

February 10.

Raynaud's Disease in a Man of 67—Dr. R. O. Burrell

Raynaud's Disease in a patient of this age is very uncommon. This man was under treatment for lues but the condition was not regarded as due to syphilis. Novocaine block was followed by absence of the usual reaction to cold and suggested preganglionic sympathectomy for permanent relief. This operation was performed with apparent cure.

Arterial Embolism—Dr. R. O. Burrell

A man of 71, suffering from heart failure of long standing developed embolism. The clot lodged at the bifurcation of the brachial and the arm had been white, cold and pulseless for nearly 18 hours. The terminal two inches of the brachial, and the proximal inch of the ulnar and radial arteries were resected. The collateral circulation was proven to be good. The upper thoracic ganglia were injected with novocaine daily for 25 days in order to relax the collateral vessels. (Distension of the artery by embolus induces a vasospastic reflex.) Recovery was prompt and complete.

Coagulum Contact Graft—Dr. R. O. Burrell

The case presented was a man whose calf had been largely denuded as the result of an accident. The large area was covered with a graft held in place by the physiological cement devised by Sano of Philadelphia. This method requires neither pressure bandages nor sutures. Within 24 hours after the operation the graft had taken firmly and four days later the wound was quite healed.

St. Joseph's Hospital

Impacted Teeth

Dr. W. Robb

Dr. Robb pointed out that the incidence of impacted teeth has increased with the present generation. The third molar tooth is present in 75% of the cases; of these it erupts normally in 40% of the cases, and in the other 60% presents an impaction.

The impactions must be cared for at some time during the patient's life. In advanced years the removal of an impacted third molar tooth presents great difficulties, therefore, the eruption of all third molar teeth should be provided for in early life.

This can be done by the removal of the six year molars before the age of ten, the removal of the second molars before the age of fifteen, or preferably the removal of the impacted teeth.

By transferring the surgery from bone to tooth, (i.e. splitting the impacted tooth to facilitate its removal, rather than cutting away bone), severe post-operative reactions can be eliminated.

Dr. Robb presented five case histories where impacted teeth had caused a great deal of discomfort and suffering.

The patients were relieved of their symptoms following extraction.

A.L.S.

Winnipeg General Hospital

A Case of Renal Carcinoma

Dr. C. B. Stewart

A female, aged 61, had haematuria for 15 hours, anuria 24 hours. Twenty years ago she was treated for haematuria which cleared up with rest in bed.

On admission B.U.N. was 18. X-ray studies of kidney and bladder showed a tumour of the kidney pelvis.

Operative Findings: Open ether anaesthesia; intravenous fluid and blood were given on the table. The tumour extended from the kidney along the renal vein towards the vena cava. In removing the kidney and tumour the renal vein was torn, which necessitated leaving a clamp on for some five days. At the end of this period the clamp was removed without difficulty.

Dr. Stewart showed X-ray studies of other types of kidney malignancy. Excellent slides in colour were projected to show this tumour upon removal and also another malignant tumour.

Dr. Morse contributed to the discussion.

★

Acute Atelectasis

Dr. D. L. Scott

A female, aged 38, had haemoptysis from January 6th to January 13th. Previous illnesses: at 4 years she had bronchitis. Some years later had erysipelas, pneumonia, acute mastoidectomy, and acute otitis media some time after the mastoidectomy. Dr. Scott wished to tie in the relationship between upper and lower respiratory infections.

On January 13th this patient was acutely ill with chest retraction, dyspnoea and some cyanosis, suggesting atelectasis. An X-ray picture confirmed this diagnosis. By the use of posture and other forms of treatment two days later, on January 15th, the lung

had re-expanded and the patient looked normal. X-ray picture confirmed a re-expansion of the lung.

Those taking part in the discussion were Drs. Adamson, Hunter and Rennie. The consensus of opinion was that simple measures should be tried first in cases of atelectasis, but after 12 to 24 hours with elevated temperature, increased pulse rate and dyspnoea, bronchoscopy by an expert was indicated.

★

Travelogue — American Orthopedic Association Meeting In Chicago

Dr. E. S. James

The speaker gave indications and contraindications for the use of Penicillin. He mentioned that Penicillin destroys the tetanus bacilli but is ineffective against the toxin. In using Penicillin in the treatment of tetanus one must also give tetanus antitoxin. Penicillin should cure acute osteomyelitis. It is estimated that of the casualties evacuated from the battle field 65% are orthopedic cases. The use of Penicillin pre-operatively and post-operatively allows surgeons to do bone grafts and nerve suturing upon battle casualties many months in advance as before the use of Penicillin. There is a calcium salt of Penicillin which retains its potency for two months at room temperature.

External Fixation of Fractures: Dr. James showed a method of fixation of fractures by the use of four pins. He gave a resume of cases suitable and unsuitable for the use of this type of apparatus. "Pin sequestra," arterio-venous aneurysm, and too great traction keeping the fractured ends of bones apart, resulting in non-union, are unfavorable sequelae following this type of treatment. D.C.A.

★

Various Types of Skin Grafts

Dr. C. W. Burns

Dr. Burns gave a most interesting and practical demonstration of various types of skin grafts. The first was rather an obese man with pedicle graft to the right orbital area. The next was a young man with a stiff finger which was treated with a pedicle graft with marked improvement of the affected finger. The third case was an elderly man with a compound fracture of the tibia and fibula. An area was treated with a pedicle graft, with good result. The fourth case was a burn of the popliteal space treated by a Thiersch graft.

Dr. Burns pointed out that in choosing a graft he massaged the area before taking a graft in order to get as much blood as possible into the graft. He said it was wise to choose the colour of the graft to match the skin in the affected area; also in a pedicle graft if too much fat is left on, if the patient later becomes obese the graft shares in the obesity.

Those taking part in the discussion were Drs. Kitchen, Onhauser and MacCharles.

★

Tuberculosis in Animals

Dr. D. Nicholson and Dr. L. G. Bell

Dr. Nicholson mentioned veterinary surgeons giving papers on disease in animals which in many instances were similar to disease in human beings. Of pet dogs 1 to 5% have open tuberculosis; the organism has been cultured to prove the diagnosis. Animals apparently are equally susceptible to human or bovine tuberculosis. In pet dogs the organism is mostly the human type, which is due to contact. It is estimated that 75% of canine tuberculosis is pulmonary and 25% is alimentary; the latter is mostly the bovine organism. Goats are not so susceptible. Opinion of the group was divided regarding the value of goat's milk as superior to that of cow's milk as a food for invalids.

Those taking part in the discussion were Drs. Scott, Speechly, Young and Donovan.

Misericordia Hospital

Treatment of After Effects of Burns—Dr. Deacon

Dr. Deacon showed a case where severe contracture had followed a burn of the leg. Treatment was by extension and by the use of grafts to cover the denuded area.

Burns to the Face

Dr. Reznowski presented the results following simple treatment of burns of the face.

Victoria Hospital

January, 1944.

Actinomycosis of the Pelvis

Dr. W. F. Tisdale

A farmer age 34 was in good health until two years ago. At that time he developed indigestion and vague abdominal pains. Appendectomy was performed at that time. He developed acute intestinal obstruction 1 year ago, a colostomy was done which was closed 6 months later. Patient had a hard nodular mass in the rectum which was diagnosed as carcinoma.

Admitted to the hospital in December, 1943, with discharging sinuses from the abdomen and pelvis. A diagnosis of actinomycosis was made. The mass which was present in the rectum previously disappeared.

Treatment: Large doses of potassium iodide and sulfa drugs. The value of deep x-ray therapy and penicillin was discussed. Dr. J. M. Lederman discussed the pathology of actinomycosis.

A. L. Shubin, M.D.

★

Refresher Course in Otolaryngology

The Department of Otolaryngology of the University of Illinois College of Medicine announces its spring refresher course, to be held at the College in Chicago, March 20 to 25, incl., 1944. The course will be largely didactic, but some clinical demonstrations have been included. It is intended primarily for specialists, who under existing conditions, are able to devote only a brief period to post-graduate review study. The fee is $50.00. Registration will be limited. In letter requesting application, state school and year of graduation; also give details concerning specialty training and experience. Address Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

★

Obituary

Dr. Alexander Lawson

Dr. Alexander Lawson, 77, who practised in several Manitoba towns before retiring and going to Victoria, B.C., 20 years ago, died Saturday, January 29th, 1943, at Victoria. He was born in Waterdown, Ont., registered in Manitoba, August 12th, 1890, and practised at Shoal Lake, Hamiota, Elgin and Carberry.

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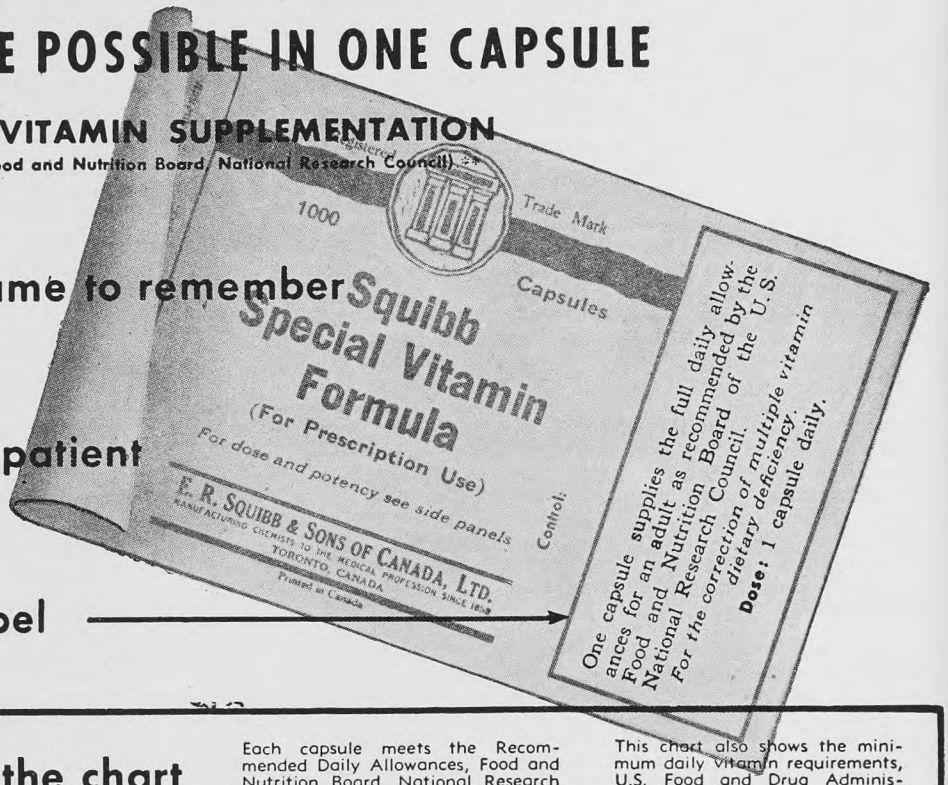

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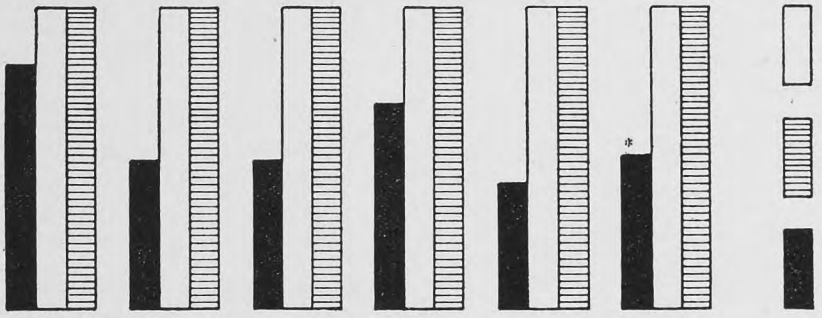

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**J.A.M.A. 116:2601, June 7, 1941.

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Editorial

The birth will shortly be announced of the Manitoba Health Plan. The long period of gestation is nearing its end and already a "show" has appeared in the ballot papers recently distributed. It is nearly 15 months ago that an open meeting appointed an "amending" committee which moulded the bill into an acceptable form. Since then progress has been slow but at last prospera lux oritur — the happy day arrives and no longer need the surgical patient or the surgeon worry about the bill.

This issue is devoted to Health Insurance. The February meeting of the Winnipeg Medical Society was addressed by three laymen, who gave their views upon the subject. What was said you can read for yourselves. The speakers had obviously made a close study of the subject. To those for whom they spoke Health Insurance is of prime importance, for among them are many who live from day to day and whose chief stock-in-trade is the ability to work. It was discouraging to hear Mr. King say that few of the laboring classes could afford to subscribe to Health Insurance. The plan is almost worthless if it cannot help, above all, the poorest paid. It is with them that our sympathies lie and for them that we would do most. Our aim is not a minimum service but an optimum service and especially to those who need it most. Both labor and agriculture hold the view that in any plan the doctor must be a partner and not a servant. One felt that in the inevitable adjustments which must be made before the plan goes into effect there will be a spirit of co-operation between the interested parties a sincere desire to obtain maximum benefits for all but not at the cost of any one group. It was a useful and illuminating meeting.

We have received for review The Hebrew Medical Journal. This is printed in both Jewish and English, has an imposing international advisory committee and gives a comprehensive view of Jewish Medicine throughout the free world. For our Jewish colleagues, especially, it contains much of interest. It can be obtained from the Medical Library. J. C. H.

Did You?

During the 30 days following the mailing of our letter requesting renewals to membership in the Association for 1944, 252 replied, enclosing their cheques. Of these, 13 were new members whom we are glad to welcome. This splendid response is very gratifying to the Executive and benefits the members who responded in that there will be no interruption in the receipt by them of the Journals. As you know, the Canadian Medical Editorial Department does not guarantee to supply back issues of the Journals if subscriptions are not in by the end of March.

In view of the importance of every man enrolling in the Association, we think the fee of $15.00 should be no barrier to membership. This makes you a member of the Canadian Medical Association and the Manitoba Division, and brings to your desk each month two Journals, which are of very definite value to you in these times of change.

If, through an oversight you neglected sending in your renewal subscriptions and membership dues.

Will You Do It Now?

W.G.B.

Obituary

Dr. George Clingan, of Virden, died in Virden General Hospital on January 24th from injuries sustained the previous day. As district coroner he was on his way to view the spot where a fatal motor cycle accident had occurred a few days earlier. Approaching a sharp curve Dr. Clingan's car plunged into a deep gully near Pipestone Creek, and the three occupants were injured.

Dr. Clingan's life was one of service in many fields—medicine, the army, and the legislature. Born near Orangeville, Ont., in 1868, he graduated in Toronto University in 1892. He was resident physician at Toronto Children's Hospital, a member of the staff of that hospital from 1893 to 1895, and taught physiology in Toronto Medical College for two years. In 1898 he came to Virden and practised there till his death. He was mayor of the town in 1908 and 1909 and health officer for 30 years for Virden and the municipality of Wallace.

In 1899 he enlisted with the 12th Manitoba Dragoons and rose to the rank of Major. In 1915 he raised the 79th Battalion at Brandon and went overseas at its head with the rank of Lieutenant-Colonel. He commanded No. 2 Canadian Hospital at Outreau, France, and the Canadian Convalescent Hospital at Monk's Horton, England. At the time of his death he was recruiting officer for Virden district, M.D. 10.

He represented Virden constituency in the Manitoba legislature from 1914 to 1922, supporting the Norris Liberal party.

Organized medicine found in him a staunch supporter. He was one of the mainstays of the North Western District Medical Society. For many years he served on the executive of the Manitoba Medical Association; in 1936 was president, and in 1942 was made an honorary member. From his graduation he was a member of the Canadian Medical Association and in 1940 he attained the honour of being made a senior member.

He is survived by his widow, a daughter and three grandchildren.

George Clingan stood for high standards in his profession. It was fitting that death should come to him in the path of duty after a full active life. His sunny disposition won him many friends. In Chaucer's phrase he was "a verray, parfit, gentil knyght."

★

Officers' Mess, A 22 C.A.M.C. T.C.,
Camp Borden, Ont. 15 Feb., 1944.

Manitoba Medical Association,
c/o Dr. Ross Mitchell,

Dear Doctor Mitchell:

As you know, this is the only R.C.A.M.C. Mess in Canada. We have anywhere from 50 to 100 medical men through here most of the time in addition to approximately 20 M.O.s serving as instructors. These men are from all parts of Canada and I feel sure are interested in the activities among the doctors in their own and neighbouring provinces. With this in mind may I request that your Medical Association send to this Mess copies of any material which you may publish, such as a monthly Bulletin. Our Library in the Mess is deplorably short of reading material and I am taking this course in an attempt to build it into something worth while. I sincerely hope that you do not regard this request as too unorthodox and that you may contribute your Journal or Bulletin to our Mess; the men will all appreciate your consideration. Cordially yours,

C. M. Robertson, Capt. R.C.A.M.C.

I imagine any medical literature will be welcome. Will our readers send anything and everything they can to Capt. Robertson? J.C.H.

CASE HISTORY

Case No 2

Patient	B.M. - age 60 - Journalist
Blood Wassermann	plus 4
Cerebrospinal	plus 4
Colloidal gold	5554432211

PAST HISTORY

In the last war the patient received a shot in the buttocks and during treatment in the rear he showed signs of mental instability. 1916.

For sex perversion and offences against law and decency, he was later confined to jail, resulting in a pronounced claustrophobia. Early sexual life was most irregular, and inadequately treated, syphilis may have been contracted from one of a succession of venereal mistresses to which the patient admits. he has three legitimate children but no others to speak of.

Definite mental aberrations were established at this time, some illusory extravagances astonishing friends and relatives. (e.g. during a train ride he believed himself making a military assault upon the capital of his country.)

The patient lived in enormous rooms to satisfy his expansive moods and to accomodate his exaggerated thoracic enlargement and acute lordosis.

HISTORY OF PRESENT ILLNESS

Mentally and physically the patient's health has deteriorated since 1930. In 1935 the patient took a darker outlook on life during a trip to Ethiopia. In 1940 while in France the patient perpetrated a back stabbing crime and other acts of violence, showing unbalanced mental reactions. In 1942, while watching cross-country races in Tunisia, he suffered a complete mental and physical breakdown.
Although the patient seeks refuge in a home for incurables his ultimate fate seems inescapable.

DIAGNOSTIC IMPRESSION

General paresis of the insane.

TREATMENT

Heavy metals (Eisenhower)
Seclusion and rest (Gestapo) - Lead .303
Note: Patient refused castor oil treatment claiming he had recommended it to others with poor results.

Association Page

Steady! This is Not the Only Generation that Has Suffered

The following is, in part, reprinted from Macaulay's Essay on Southey's Colloquies on Society, published in Edinburgh Review, January, 1830.

History is full of the signs of this natural progress of society. We see in almost every part of the annals of mankind how the industry of individuals, struggling up against wars, taxes, famines, conflagrations, mischievous prohibitions and more mischievous protections, creates faster than governments can squander, and repairs whatever invaders can destroy.

We see the capital of nations increasing and all the arts of life approaching nearer and nearer to perfection in spite of the grossest corruption and the wildest profusion on the part of rulers.

The present moment is one of great distress. But how small will that distress appear when we think over the history of the last forty years; a war, compared with which, all other wars sink into insignificance; taxation, such as the most heavily taxed people of former times could not have conceived; a debt larger than all the public debts that ever existed in the world added together; the food of the people studiously rendered dear; the currency impudently debased, and improvidently restored.

Yet is the country poorer than in 1790? We fully believe that, in spite of all the misgovernment of her rulers she has been almost constantly becoming richer and richer. Now and then there has been a stoppage, now and then a short retrogression; but as to the general contingency there can be no doubt. A single breaker may recede; but the tide is evidently coming in.

We prophesy nothing; but this we can—if any person had told the Parliament which met in perplexity and terror after the crash of 1720 that in 1830 the wealth of England would surpass all the wildest dreams, that the annual revenue would equal the principal of that debt which they considered an intolerable burden—our ancestors would have given as much credit to the prediction as they gave to Gulliver's Travels.

Hence it is, that though, in every age, everybody knows that up to his own time progressive improvement has been taking place, nobody seems to reckon on any improvement during the next generation.

We cannot absolutely prove that those are in error who tell us that society has reached the turning point—that we have seen our best days. But so said all who came before us, and with just as much apparent reason.

"A million a-year will beggar us," said the patriots of 1640.

"Two millions a-year will grind the country to powder," was the cry in 1660.

"Six millions a-year and a debt of fifty millions!" exclaimed Swift, "the high allies have been the ruin of us."

"A hundred and forty millions of debt!" said Junius, "well may we say that we owe Lord Chatham more than we shall ever pay, if we owe him such a load as this."

"Two hundred and forty millions of debt!" cried all the statesmen of 1783 in chorus, "what abilities, or what economy on the part of a minister, can save a country so burdened?" We know that if, since 1783, no fresh debt had been incurred, the increased resources of the country would have enabled us to defray that burden, at which Pitt, Fox and Burke stood aghast—to defray it over and over again—and that with much lighter taxation than what we have actually borne. On what principle is it, that when we see nothing but improvement behind us, we are to expect nothing but deterioration before us?

It would seem from the perusal of the above that each generation has to travel its own "Via Dolorosa," that mankind tends to look backward upon the fixed and known conditions rather than contemplate the unknown of the future. This war will end some day. The boys will perhaps not come marching home but they will return. Are we prepared to aid their re-entry into civil life?

Of medical men in the Armed Forces about to be demobilized we find two groups—those who have engaged in practice and those who went directly to the Services from Medical School. The first consists of men of more or less established position before enlistment who are now five years older. Due to service conditions, some may find that physically they are nearer ten than five calendar years older than at time of enlistment. The second group will need refresher courses to equip them for the work the war had interrupted.

The patients who had their medical needs attended to by group one in pre war days may have sought medical advice from civilian colleagues during the war. Are we prepared to aid the return of these patients to their former medical advisers? As an Association we can pass pious resolutions promising our Service brethren unending help in their civil re-establishment, but, as individuals, let us definitely and clearly tell Mrs. Jones, Mr. Brown, and the whole White family that Captain, Major, or Colonel Blank is home ready to assume their medical care.

If our colleagues of Group One in the Services feel that we civilians are ready to lend a hand in their return to civil life and the Second Group realize that they are not forgotten, despite their youth, the "pull" to remain in the Services during the post war period would not be so alluring. Both these groups would feel that organized medicine welcomed their return to normal civilian life. It is not too early for the profession to consider ways and means for an orderly absorption of medical service men into what we hope shall be a better and more populous Canada.

D.C.A.

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Dauphin District Society

On Wednesday evening, February 9th, the Dauphin General Hospital acted as host to a well attended meeting of Dauphin District Society. The dinner was a sumptuous one. If the way to reach a man's heart is through his tummy, the dietitian at Dauphin Hospital knows her way around.

After dinner the group adjourned to the recreation room. Dr. Malcolm, a competent and genial chairman, extended a welcome to all, especially to those who had motored some thirty miles.

Dr. R. O. Burrell, of Winnipeg, gave a most interesting and thorough talk upon (1) Tumours of the Mammary Breast, and (2) Intestinal Obstruction. The latter was aided by the presentation of numerous X-Ray pictures to demonstrate various types of intestinal obstruction. A lively discussion followed. Dr. T. F. Malcolm, on behalf of the group, extended a hearty vote of thanks to Dr. Burrell for his excellent address.

Your President gave a somewhat lengthy review of Health Insurance. He stressed the need of preserving teaching material in the proposed National Health Insurance Scheme and differentiated the respective merits of fee for service, capitation, and salary. In the discussion, which lasted until 24:15 hours, it was apparent that the group realized the complexity of the proposed National Contributory Health Insurance Act.

D.C.A.

Personal Notes and Social News

Major Cecil W. Clark, R.C.A.M.C., has been promoted to the rank of acting Lieutenant-Colonel, National Defence Headquarters announced.

★

Dr. and Mrs. Bruce Chown have returned from several weeks' visit to Montreal and New York.

★

Dr. and Mrs. J. M. Ridge of Hodgson, Man., are receiving congratulations on the birth of a daughter (Margaret Anne) at the Winnipeg General Hospital, on February 5th, 1944.

★

Surgeon-Lieutenant Edgar M. Gee, R.C.N.V.R., son of Mr. and Mrs. F. M. Gee of Winnipeg, was married on January 15th at the chapel of H.M.C.S. Cornwallis, Cornwallis, N.S., to Nursing Sister Walterina Scott MacFarlane, R.C.N., of Chesley and Ottawa, Ont., daughter of Mr. and Mrs. Alex. MacFarlane of Chesley, Ont. Surg.-Lieut. Gee and Mrs. Gee will reside in Hamilton, Ont., where he is attached to H.M.C.S. Star.

★

Dr. and Mrs. J. A. Waugh are happy to announce the birth of a daughter (Marie Frances) at the Winnipeg General Hospital, on February 21st, 1944.

★

Dr. Tom L. and Mrs. Quong announce the birth of a son (Tom Herbert Ewen) on February 5th, 1944, at the Winnipeg General Hospital (premature).

★

The promotion of Major Wilfred M. Musgrove, R.C.A.M.C., to Lieutenant-Colonel and his appointment as officer commanding Fort Osborne Military Hospital, has been announced by military authorities.

★

Dr. S. B. Thorson, formerly of the Winnipeg Clinic, has joined the R.C.A.F. and at present is stationed at Brandon, Man.

★

Dr. and Mrs. N. W. Warner and their daughter, Mary Elizabeth left by plane for a month's vacation in Boston, Mass.

★

Dr. H. M. Speechly was re-elected chairman of the Advisory Traffic Commission at the inaugural meeting for 1944.

★

Major Harvey McNicol, R.C.A.M.C., recently returned from overseas, was married on Tuesday, February 29th at St. Andrew's United Church, to Nursing Sister, Lieutenant Evelyn Gregory, daughter of Mrs. Margaret Gregory, of Kitchener, Ont., formerly of Winnipeg.

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The Executive and Members of this Association desire to express their deepest sympathy to Dr. A. A. Alford of Oakville, Man., on the loss of his Mother, who died January 31st, 1944.

★

Dr. R. L. Howden's Heather Rink won the McKinney trophy in the recent Bonspiel.

★

Major E. H. Whelpley, officer commanding No. 10 company Royal Canadian Army Medical Corps, Fort Osborne barracks, has been promoted to Lieutenant-Colonel.

★

Attachment of Captain Arthur I. Lerner, R.C.A.M.C., to No. 10 district depot, Army Reception Centre, Fort Osborne barracks, from Camp Borden, Ont., has been announced.

★

Dr. and Mrs. Ross B. Mitchell are guests at the Mount Royal Hotel, Banff, Alta., where Dr. Mitchell is recuperating from his recent illness.

★

Capt. C. G. Sheps, R.C.A.M.C. is stationed at Camp Shilo Military Hospital, Camp Shilo, Man.

★

Dr. Brian Best, formerly of 105 Medical Arts Building, is now an associate at the Winnipeg Clinic.

★

Capt. J. G. Sheps, R.C.A.M.C., is stationed at the Reception Centre, Toronto, Ont.

★

A bunch of the Germs were hitting it up
In the bronchial saloon;
Two bugs on the edge of the larynx
Were jazzing a ragtime tune.
While back of the teeth in a solo game
Sat dangerous Dan Kerchoo,
And watching his pulse was his light of love,
The lady that's known as Flu.

—Toronto Evening Telegram
(Thomas Richard Henry)

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A good prognosis is the best of tonics for a cardiac patient.—Lindsay.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944 Dec. 5 to Dec. 31,'43	1944 Jan. 1 to Jan. 29,'44	1942 Dec. 3 to Dec. 31,'42	1942 Jan. 1 to Jan 30,'43
Anterior Poliomyelitis	-----	-----	2	4
Chickenpox	359	310	417	268
Diphtheria	20	7	24	20
Diphtheria Carriers	6	4	2	2
Dysentery—Amoebic	-----	-----	-----	-----
Dysentery—Bacillary	1	-----	1	1
Erysipelas	6	6	2	6
Encephalitis	1	-----	-----	1
Influenza	135	23	19	38
Measles	30	116	43	98
Measles—German	-----	5	3	-----
Meningococcal Meningitis	1	1	1	3
Mumps	189	180	277	437
Ophthalmia Neonatorum	-----	-----	-----	-----
Pneumonia—Lobar	11	8	13	18
Puerperal Fever	1	-----	-----	-----
Scarlet Fever	213	258	55	45
Septic Sore Throat	7	1	2	-----
Smallpox	-----	-----	-----	-----
Tetanus	-----	-----	-----	-----
Trachoma	-----	-----	-----	1
Tuberculosis	48	34	32	28
Typhoid Fever	1	-----	2	3
Typhoid Paratyphoid	-----	-----	-----	-----
Typhoid Carriers	-----	-----	-----	-----
Undulant Fever	1	-----	2	-----
Whooping Cough	40	16	120	167
Gonorrhoea	112	139	110	174
Syphilis	45	48	53	45
Meningococcal Meningitis Carriers	-----	-----	-----	2

DISEASE	*738,000 Manitoba Jan. 1-29,'44	*3,825,000 Ontario Jan. 1-29,'44	*906,000 Saskatchewan Jan. 1-29,'44	*2,972,300 Minnesota Jan. 1-29,'44	*641,935 North Dakota Jan. 1-29,'44
*Approximate populations.					
Anterior Poliomyelitis	----	----	----	1	----
Meningococcal Meningitis	1	21	2	23	8
Chickenpox	310	1570	197	----	----
Diphtheria	7	21	11	14	12
Dysentery—Amoebic	----	----	----	3	----
Erysipelas	6	8	----	----	1
Influenza	23	526	7	5	860
Encephalitis	----	----	----	----	1
Measles	116	1447	139	2445	1185
German Measles	5	62	9	----	----
Mumps	180	852	22	----	18
Puerperal Fever	----	1	----	----	----
Scarlet Fever	258	786	83	521	67
Septic Sore Throat	1	5	----	----	----
Smallpox	----	----	----	----	1
Trachoma	----	----	----	----	7
Tuberculosis	34	204	2	15	31
Tularemia	----	----	----	----	1
Typhoid Fever	----	1	----	----	1
Undulant Fever	----	1	----	12	2
Whooping Cough	16	467	62	138	21
Diphtheria Carriers	4	----	----	----	----
Gonorrhoea	139	599	----	----	10
Syphilis	48	669	----	----	12

DEATHS FROM COMMUNICABLE DISEASES

December, 1943

URBAN — Cancer 55, Influenza 28, Tuberculosis 12, Pneumonia (lobar) 9, Pneumonia (other forms) 8, Syphilis 4, Lethargic encephalitis 1, Cerebrospinal meningitis 1, Hodgkin's Disease 1, Mumps 1, Septic Sore Throat 1. Other deaths under 1 year 19. Other deaths over 1 year 262, Stillbirths 17. Total 419.

RURAL — Cancer 29, Influenza 27, Pneumonia (other forms) 14, Tuberculosis 10, Pneumonia Lobar 8, Syphilis 4, Whooping Cough 2, Dysentery 2, Measles 1, Infectious Jaundice 1, Hodgkin's Disease 1. Other deaths under 1 year 19. Other deaths over 1 year 252. Stillbirths 17. Total 387.

INDIANS — Tuberculosis 24, Whooping Cough 9, Pneumonia (other forms) 8, Measles 5, Pneumonia Lobar 4, Influenza 3, Cerebrospinal meningitis 1. Other deaths under 1 year 9. Other deaths over 1 year 9. Stillbirths 2. Total 74.

REGISTRY OF CRIPPLED CHILDREN

Department of Health and Public Welfare Bldg.

320 Sherbrook Street

Winnipeg, Manitoba

This Registry has been opened for the purpose of finding the children in Manitoba who are crippled.

When necessary, the Junior Red Cross will assist in procuring treatment.

Register the names of all crippled children under the age of 17 years.